		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040683

Facility Name: Alden Long Grove Rehab & HC Ct

Address: Box 2308, RFD Old Hicks Rd. (Number) Long Grove (City) 60047 (Zip Code)

County: Lake

Telephone Number: (773)286-3883 **Fax #** (773) 286-3743

IDPA ID Number: 36-4003486

Date of Initial License for Current Owners: 03/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven M. Kroll

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	248	Skilled (SNF)	248	90,520	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	90,520	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,086	921	3,892	7,899	8
9	SNF/PED					9
10	ICF	46,050	6,002	532	52,584	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,136	6,923	4,424	60,483	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.82%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 3/1/95

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 3/1/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 53 and days of care provided 3,451

Medicare Intermediary AdminiStar Federal, Inc

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	359,444	46,385		405,829	459	406,288		406,288			1
2	Food Purchase		402,265		402,265	(34,720)	367,545	(12,186)	355,359			2
3	Housekeeping	191,783	32,467		224,250	821	225,071		225,071			3
4	Laundry	71,022	14,070		85,092		85,092		85,092			4
5	Heat and Other Utilities			157,585	157,585		157,585		157,585			5
6	Maintenance	39,158		125,003	164,161	79	164,240	11,944	176,184			6
7	Other (specify):*											7
8	**TOTAL General Services**	661,407	495,187	282,588	1,439,182	(33,361)	1,405,821	(242)	1,405,579			8
	B. Health Care and Programs											
9	Medical Director			45,500	45,500		45,500		45,500			9
10	Nursing and Medical Records	2,685,370	202,371	6,116	2,893,857	3,714	2,897,571	(7,512)	2,890,059			10
10a	Therapy	4,079			4,079		4,079		4,079			10a
11	Activities	117,302	5,236	1,247	123,785	50	123,835		123,835			11
12	Social Services	32,322			32,322		32,322		32,322			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,839,073	207,607	52,863	3,099,543	3,764	3,103,307	(7,512)	3,095,795			16
	C. General Administration											
17	Administrative	179,816			179,816		179,816		179,816			17
18	Directors Fees											18
19	Professional Services			744,482	744,482		744,482	(656,286)	88,196			19
20	Dues, Fees, Subscriptions & Promotions			34,434	34,434		34,434	(19,023)	15,411			20
21	Clerical & General Office Expenses	540,947	16,293	21,492	578,732	9	578,741	46,727	625,468			21
22	Employee Benefits & Payroll Taxes			440,774	440,774	29,588	470,362	68,837	539,199			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,175	1,175		1,175	13,583	14,758			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			133,725	133,725		133,725	(7,192)	126,533			26
27	Other (specify):*			54,771	54,771		54,771	(54,771)				27
28	**TOTAL General Administration**	720,763	16,293	1,430,853	2,167,909	29,597	2,197,506	(608,125)	1,589,381			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,221,243	719,087	1,766,304	6,706,634		6,706,634	(615,879)	6,090,755			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct #0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			91,007	91,007		91,007	12,537	103,544			30
31	Amortization of Pre-Op. & Org.							3,366	3,366			31
32	Interest			376,392	376,392		376,392	(329,950)	46,442			32
33	Real Estate Taxes			98,300	98,300		98,300	7,351	105,651			33
34	Rent-Facility & Grounds			1,881,307	1,881,307		1,881,307	675	1,881,982			34
35	Rent-Equipment & Vehicles			10,584	10,584		10,584	25,205	35,789			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,457,590	2,457,590		2,457,590	(280,816)	2,176,774			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		140,272	484,588	624,860		624,860	(328,483)	296,377			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,780	135,780		135,780		135,780			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		140,272	620,368	760,640		760,640	(328,483)	432,157			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,221,243	859,359	4,844,262	9,924,864		9,924,864	(1,225,178)	8,699,686			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(888)	2		13
14	Non-Care Related Interest	(45)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(27,827)	32		18
19	Entertainment				19
20	Contributions	(4,664)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(54,771)	27		24
25	Fund Raising, Advertising and Promotional	(10,116)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,465)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (101,776)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(661,595)	pg 6's	34
35	Other- Attach Schedule	(461,807)	pg 5a	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,123,402)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,225,178)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Long Grove Rehab & HC Ct

ID# 0040683

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Seminar prior year expense adj backed out on p.5A	$ 310	24	1
2	Illinois healthcare Association - pac fees backed out	(1,100)	20	2
3	Self insurance adjustment	(7,192)	26	3
4	non-cost: hmo nursing supply (gl 5026)	(1,723)	39	4
5	non-cost: hmo drugs supply (gl 5042)	(18,626)	39	5
6	non-cost: hmo therapy (gl 5040)	(74,875)	39	6
7	painting>$1,500 for 2000	2,900	6	7
8	painting>$1,500 for 2001	341	6	8
9	non-cost: hmo oxygen c/a (gl 5080)	(392)	39	9
10	back out related party interest expense gl 7105	(348,565)	32	10
11	adj deprec exp to correct ytd 2001 total	(473)	30	11
12	back out non-costs: part b c/a's in 5212/3/4	(10,364)	39	12
13	back out 2001 painting>$1,500 (exp'd above)	(2,048)	6	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(461,807)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(888)	0	0	(11,298)	0	0	0	0	0	0	0	(12,186)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,193	0	10,754	0	0	0	(3)	0	0	0	0	11,944	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	305	0	10,754	(11,298)	0	0	(3)	0	0	0	0	(242)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(6,177)	(1,335)	0	0	0	0	0	0	(7,512)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(6,177)	(1,335)	0	0	0	0	0	0	(7,512)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(656,286)	0	0	0	0	0	0	0	0	(656,286)	19
20	Fees, Subscriptions & Promotions	(19,345)	0	322	0	0	0	0	0	0	0	0	(19,023)	20
21	Clerical & General Office Expenses	0	0	31,129	10,993	4,605	0	0	0	0	0	0	46,727	21
22	Employee Benefits & Payroll Taxes	0	0	67,893	0	944	0	0	0	0	0	0	68,837	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	310	0	13,273	0	0	0	0	0	0	0	0	13,583	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(7,192)	0	0	0	0	0	0	0	0	0	0	(7,192)	26
27	Other (specify):*	(54,771)	0	0	0	0	0	0	0	0	0	0	(54,771)	27
28	**TOTAL General Administration**	(80,998)	0	(543,669)	10,993	5,549	0	0	0	0	0	0	(608,125)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(80,693)	0	(532,915)	(6,482)	4,214	0	(3)	0	0	0	0	(615,879)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(473)	0	11,855	0	1,155	0	0	0	0	0	0	12,537	30
31	Amortization of Pre-Op. & Org.	0	0	250	0	0	3,116	0	0	0	0	0	3,366	31
32	Interest	(376,437)	0	39,120	0	1,763	5,604	0	0	0	0	0	(329,950)	32
33	Real Estate Taxes	0	0	7,050	0	301	0	0	0	0	0	0	7,351	33
34	Rent-Facility & Grounds	0	0	675	0	0	0	0	0	0	0	0	675	34
35	Rent-Equipment & Vehicles	0	0	25,205	0	0	0	0	0	0	0	0	25,205	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(376,910)	0	84,155	0	3,219	8,720	0	0	0	0	0	(280,816)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(105,980)	0	0	(14,786)	(34,554)	(173,163)	0	0	0	0	0	(328,483)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(105,980)	0	0	(14,786)	(34,554)	(173,163)	0	0	0	0	0	(328,483)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(563,583)	0	(448,760)	(21,268)	(27,121)	(164,443)	(3)	0	0	0	0	(1,225,178)	45

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits	$	Alden Management Services, Inc.	100.00%	$ 67,893	$ 67,893	15
16	V	19	Management fees	667,982	Alden Management Services, Inc.		11,696	(656,286)	16
17	V	21	Gen'l & Admin.		Alden Management Services, Inc.		31,129	31,129	17
18	V	6	maintenance/utilities		Alden Management Services, Inc.		10,754	10,754	18
19	V	24	autos/seminars		Alden Management Services, Inc.		13,273	13,273	19
20	V	20	dues/subscriptions		Alden Management Services, Inc.		322	322	20
21	V	30	depreciation		Alden Management Services, Inc.		11,855	11,855	21
22	V	31	amortization		Alden Management Services, Inc.		250	250	22
23	V	33	real estate tax		Alden Management Services, Inc.		7,050	7,050	23
24	V	34	rent		Alden Management Services, Inc.		675	675	24
25	V	35	rent-equipt/vehicles		Alden Management Services, Inc.		25,205	25,205	25
26	V	32	interest		Alden Management Services, Inc.		39,120	39,120	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 667,982			$ 219,222	$ * (448,760)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	TUBE FEEDINGS	$ 20,700	PYRAMID HEALTH CARE SERVICES	100.00%	$ 9,402	$ (11,298)	15
16	V	10	NURSING SUPPLIES	10,704	PYRAMID HEALTH CARE SERVICES		4,527	(6,177)	16
17	V	39	SUPPLIES / PER DIEM FEES	36,064	PYRAMID HEALTH CARE SERVICES		21,278	(14,786)	17
18	V	21	GENERAL & ADMIN.		PYRAMID HEALTH CARE SERVICES		10,993	10,993	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 67,468			$ 46,200	$ * (21,268)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 118,310	Forum Extended Care II	100.00%	$ 92,705	$ (25,605)	15
16	V	10	house stock	6,165	Forum Extended Care II		4,830	(1,335)	16
17	V	39	iv	41,349	Forum Extended Care II		32,400	(8,949)	17
18	V	22	fringe benefits		Forum Extended Care II		944	944	18
19	V	21	gen'l & admin		Forum Extended Care II		4,605	4,605	19
20	V	32	interest		Forum Extended Care II		1,763	1,763	20
21	V	33	real estate		Forum Extended Care II		301	301	21
22	V	30	depreciation		Forum Extended Care II		1,155	1,155	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 165,824			$ 138,703	$ * (27,121)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	CPT REVENUES	$ 353,957	COMMUNITY PHYSICAL THERAPY	100.00%	$ 180,794	$ (173,163)	15
16	V	31	AMORTIZATION		COMMUNITY PHYSICAL THERAPY		3,116	3,116	16
17	V	32	INTEREST		COMMUNITY PHYSICAL THERAPY		5,604	5,604	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 353,957			$ 189,514	$ * (164,443)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance expenses	$ 603	Alden Bennett Construction	100.00%	$ 600	$ (3)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 603			$ 600	$ * (3)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	100.00	336,545	3.57	5.95	salary	$ 21,280	21-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.00	75,346	2.38	5.95	salary	4,764	21-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	68,831	2.38	5.95	salary	4,352	21-1	3
4											4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	$ 30,396		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8a…				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	RELATED PARTY - CPT	X		OPERATIONS	NONE					VARIES	5,604	6
7	Related Party - AMS/FECII	X		OPERATIONS	NONE					VARIES	40,883	7
8												8
9	TOTAL Facility Related						$	$			$ 46,487	9
	B. Non-Facility Related*											
10	less: interest income										(45)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (45)	14
15	TOTALS (line 9+line14)						$	$			$ 46,442	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	93,252	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	93,552	2
3. Under or (over) accrual (line 2 minus line 1).	$	300	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	98,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	98,300	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	82,889	8
1997	89,318	9
1998	90,656	10
1999	88,811	11
2000	93,552	12

LINE 4: 2001 ACCRUAL BASED ON 5% INCREASE OF ACTUAL 2001 BILL PAID:

$93,552 X 1.05 = 98,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Long Grove Rehab & HC Ct COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0040683

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-36-100-002	Nursing home facility	$ 93,551.56	$ 93,551.56
2.		Related party - Alden Management	$ 118,551.00	$ 7,050.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 212,102.56	$ 100,601.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,632 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 18,359	$	22	$	$	$ 18,359	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Related Party-Forum:										9
10	Leasehold Improvement-Remodeling			1980	19,335		20			19,335	10
11	Leasehold Improvement-Remodeling			1980	1,208		10			1,208	11
12	Leasehold Improvement-Remodeling			1986	645		5			645	12
13	Leasehold Improvement-Remodeling			1990	404		5			404	13
14	Leasehold Improvement-Remodeling			1991	94		5			94	14
15	Leasehold Improvement-Remodeling			1993	8,304	830	10	830		7,474	15
16	Leasehold Improvement-Remodeling			1993	6,504	671	9.7	671		6,035	16
17	Leasehold Improvement-sign			1994	261	22	12	22		174	17
18	Leasehold Improvement-dryvit			1995	443	44	10	44		310	18
19	Leasehold Improvement-new ac			1999	723	48	15	48		145	19
20	Leasehold Improvement-roof			1985	972	51	19	51		870	20
21	Leasehold Improvement-roof			1994	863	58	15	58		460	21
22	Leasehold Improvement-roof			1997	819	55	15	55		273	22
23	Leasehold Improvement-roof			1998	1,390	93	15	93		371	23
24	Leasehold Improvement-parking lot asphalt			2000	111	11	10	11		22	24
25	Leasehold Improvement-hallway lighting			2001	155	16	10	16		16	25
26	Leasehold Improvement-DAI			2001	195	19	10	19		19	26
27											27
28	Related Party-AMS:										28
29	Leasehold Improvement-Remodeling			1993	4,266		7			4,266	29
30	Leasehold Improvement-Remodeling			1994	2,112	64	7	64		2,112	30
31											31
32	Related Party-FECII:			1999	4,717	250	5	250		362	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SHELVING	1995	$ 5,122	$ 256	20	$ 256	$	$ 1,729	37
38	ROOF REPAIR	1995	3,000	300	10	300		2,000	38
39	STEAMER REPAIR	1995	2,686	269	10	269		1,791	39
40	EXIT DOOR-FIRE	1995	4,225	282	15	282		1,807	40
41	REPAIR BOILER/HVAC-MAJ.REP.	1995	4,712	73	5	73		4,712	41
42	PIPE/VALVE/THERMOSTAT	1996	1,460	73	20	73		456	42
43	ELECTRICAL REPAIR/INSTALLATION	1996	2,110	106	20	106		624	43
44	SIGN	1996	7,233	964	5	964		7,233	44
45	WATER HEATER ON DISHWASHER	1996	7,464	746	10	746		4,230	45
46	WALLGUARD	1996	2,096	140	15	140		769	46
47	INSTALL BOILER-MAJ.REP.	1996	33,750	1,688	20	1,688		9,141	47
48	REPLACE CONDENSOR WALK IN COOLER	1996	5,514	551	10	551		2,987	48
49	INSTALL ALUM. LOGO	1996	1,995	166	12	166		1,039	49
50	DESIGN SERVICE	1996	8,100	405	20	405		2,126	50
51	WASHROOM IMPROVEMENTS	1996	2,186	109	20	109		583	51
52	PIPING-MAJ.REP.	1996	4,000	267	15	267		1,356	52
53	PIPING-MAJ.REP.	1996	3,500	233	15	233		1,225	53
54	ATASH(replaced heat detector&fire dampers)	1997	959	192	5	192		943	54
55	ATASH(installed access panels)	1997	924	185	5	185		908	55
56	ATASH(fire alarm repairs)	1997	2,212	442	5	442		2,175	56
57	CLIMATE(installation of water heaters)	1997	7,342	1,468	5	1,468		7,098	57
58	CLIMATE(replced hydro.boiler)	1997	4,568	914	5	914		4,340	58
59	Wally's flooring(install new tiles).	1997	2,659	532	5	532		2,437	59
60	ATASH(SPRINKLER WORK)INV.#9120&9121	1997	3,072	614	5	614		2,918	60
61	ATASH(SPRINKLER WORKS)	1997	2,062	412	5	412		2,062	61
62	Climate srvc(two water heater)	1997	15,600	3,120	5	3,120		15,340	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 210,432	$ 16,739		$ 16,739	$	$ 144,983	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 210,432	$ 16,739		$ 16,739	$	$ 144,983	1
2	Wigdahl(install light fixtures)	1997	7,207	1,441	5	1,441		6,727	2
3	Wigdahl(install light fixtures)	1997	6,204	1,241	5	1,241		5,583	3
4	Climate(install compressor)	1997	6,750	1,350	5	1,350		6,075	4
5	Star contractor(door frame)	1997	2,973	595	5	595		2,626	5
6	Wally's flooring(install new tiles).	1997	2,659	532	5	532		2,526	6
7	Climate svcs(new pipe and air vents)	1997	6,354	1,271	5	1,271		5,507	7
8	EQUIPMENT INT'L LTD. (labor, parts, assembly)	1997	2,542	508	5	508		2,118	8
9	DOOR	1997	3,109	311	10	311		1,477	9
10	INSTALL NEW DROP CEILING	1997	2,175	181	12	181		861	10
11	DESIGN SERVICES	1997	931	47	20	47		229	11
12	NEW DRIVEWAY LIGHTING	1998	8,101	540	15	540		2,115	12
13	REPLACE WASHING MACHINE MOTORS	1998	1,752	350	5	350		1,372	13
14	REPLACE BOILER	1998	4,253	212	20	212		831	14
15	REPAIR PUMP MOTOR	1998	3,312	662	5	662		2,594	15
16	REPAIR DRYERS	1998	2,554	253	10	253		971	16
17	REPAIR EMEGENCY CIRCUITS	1998	1,510	151	10	151		579	17
18	REPAIR EMEGENCY LIGHTING SYSTEM	1998	273	27	10	27		105	18
19	REPLAC E COMPRESSOR	1998	1,301	130	10	130		499	19
20	REPLACE SEAVES ON ROOF	1998	10,500	700	15	700		2,392	20
21	REPLACE HOT WATER HEATER	1998	2,200	220	10	220		770	21
22	REPAIR GENERATOR	1998	5,228	349	15	349		1,162	22
23	REPLACE BEARING IN WASHER	1998	1,296	65	20	65		221	23
24	PATTEN-REPAIR GENERATOR	1998	655	33	20	33		112	24
25	PATTEN-REPAIR GENERATOR	1998	1,738	116	15	116		367	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 296,008	$ 28,024		$ 28,024	$	$ 192,802	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 296,008	$ 28,024		$ 28,024	$	$ 192,802	1
2	D.B.S. Contracting(sprinkler system installation)	1999	32,838	1,314	25	1,314		3,831	2
3	D.B.S. Contracting(sleeve pipeline for sprinkler system)	1999	5,720	572	10	572		1,668	3
4	Hobart(repair dishwasher)	1999	2,560	256	10	256		704	4
5	Climate Service (pipework for boiler and storage tank)	1999	2,032	406	5	406		1,118	5
6	D.B.S. Contracting (need invoice)	1999	3,425	343	10	343		885	6
7	Chicago Cooling (repair pump)	1999	2,482	496	5	496		1,282	7
8	AMC Building Material	1999	4,544	454	10	454		1,174	8
9	AMC Sprinklers	1999	4,238	424	10	424		1,024	9
10	System Electric(generator repair)	1999	2,720	272	10	272		612	10
11	Patten Industries(install starter)	1999	5,495	550	10	550		1,236	11
12	AMC Building Material	1999	2,063	206	10	206		464	12
13	Fox Valley(sprinkler repair)	1999	1,803	120	15	120		260	13
14	Alden Bennet Cons.install tank)	1999	6,201	628	10	628		1,308	14
15	Alden Bennet Cons.(repair wind damage)	1999	33,802	1,368	25	1,368		2,850	15
16	AMC Security system	1999	7,273	727	10	727		1,515	16
17	AMC carpentry	1999	9,435	943	10	943		1,966	17
18	Climate Service (repair HVAC)	1999	9,358	936	10	936		1,950	18
19	ABC-construction mainten. Adjustment-various	1999	6,129	409	10	409		953	19
20	Climate services (A/C REPAIR)	2000	2,482	496	5	496		993	20
21	US foodservice (Steam table for fine dining room)	2000	9,816	654	15	654		1,254	21
22	B&L Locksmith (knob set)	2000	3,750	250	15	250		458	22
23	Alden Bennett Construction (major repairs)	2000	1,791	358	5	358		537	23
24	D.B.S. Contracting (repair lawn sprikler system)	2000	1,635	327	5	327		491	24
25	D.B.S. Contracting (repair lawn sprikler system)	2000	2,285	457	5	457		686	25
26	Alden Bennett Construction (major repairs)	2000	2,907	291	10	291		388	26
27	Alden Bennett Construction (time & material billing per fac)	2000	2,315	231	10	231		251	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 465,105	$ 41,512		$ 41,512	$	$ 222,660	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 465,105	$ 41,512		$ 41,512	$	$ 222,660	1
2	alden design-architectural/designing	2000	2,628	131	20	131		186	2
3	alden design-architectural/designing	2000	3,300	165	20	165		234	3
4	ABC-time & materials-maj. Leasehold improv-various	2000	2,110	141	15	141		188	4
5	West side electric079020(wattmiser)	2001	1,362	136	10	136		136	5
6	Patten industries 1137844(major repair for electric starting motor)	2001	4,103	410	10	410		410	6
7	Alden bennett construction (drive way improvement)	2001	1,206	34	15	34		34	7
8	T & T irrigation (lawn sprinkler system)	2001	2,064	52	10	52		52	8
9	Alden bennett construction	2001	10,659	888	10	888		888	9
10	New horizons commu1884(installation hardware phone)	2001	1,986	182	10	182		182	10
11	Abc- leasehold improvement	2001	692,957	27,718	25	27,718		27,718	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,187,481	$ 71,369		$ 71,369	$	$ 252,688	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 227,417	$ 26,872	$ 26,872	$		$ 101,965	71
72	Current Year Purchases	13,055	607	607			607	72
73	Fully Depreciated Assets	38,951	898	898			38,951	73
74								74
75	TOTALS	$ 279,422	$ 28,378	$ 28,378	$		$ 141,523	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	various	bus/van	1998-2000	$ 11,938	$ 3,797	$ 3,797	$	3	$ 6,200	76
77										77
78										78
79										79
80	TOTALS			$ 11,938	$ 3,797	$ 3,797	$		$ 6,200	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,478,841	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,544	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 103,544	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 400,411	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	n/a	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	n/a	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: TL ENTERPRISES

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		248		$ 1,881,307	15	15	3
4	Additions							4
5								5
6								6
7	TOTAL		248		$ 1,881,307 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: purchase option deposit *

10. Effective dates of current rental agreement:
Beginning 3/1/95
Ending 3/1/2010

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/02	$ 1,881,307
13.	12/31/03	$ 1,881,301
14.	12/31/04	$ 1,881,307

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 10,584 Description: copy machine lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   skilled nurses on site

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 164,198	$		$ 164,198	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			25,082			25,082	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			164,676			164,676	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see pg 16a…	# of prescrpts			0	41,309		41,309	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see pg 16a…					(98,888)		(98,888)	13
14	TOTAL			$		$ 353,956	$ (57,579)		$ 296,377	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct **#** 0040683 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 64,479	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 223,000)	1,371,465		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	128,988		6
7	Other Prepaid Expenses	4,774		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): due from affiliates	10,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,579,706	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,248,699		15
16	Equipment, at Historical Cost	212,462		16
17	Accumulated Depreciation (book methods)	(395,145)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): investment in nurs home	744,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,810,016	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,389,722	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,858,064	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	244,489		30
31	Accrued Taxes Payable (excluding real estate taxes)	51,693		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,210		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	resident funds/credits	159,705		36
37	accrued expenses	1,304,175		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,660,334	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	intercompany payables	3,906,786		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,906,786	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,567,120	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,177,398)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,389,722	$	48

***(See instructions.)**

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,134,592)	1
2	Restatements (describe):		2
3	**External auditor's adjustments made after 2000 cost**		3
4	**report was submitted. These adj's have no effect on costs**		4
5	**(bad debt expense-non-allowable, and medicare revenue).**	317,542	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,817,050)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,360,348)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,360,348)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,177,398)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,833,808	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,833,808	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	191,106	6
7	Oxygen	9,208	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 200,313	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(152)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	31,805	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 31,653	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	45	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 45	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	gain on auto sale	6,591	28
28a		430	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,021	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,072,841	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,428,075	31
32	Health Care	3,094,083	32
33	General Administration	1,687,341	33
	B. Capital Expense		
34	Ownership	2,457,590	34
	C. Ancillary Expense		
35	Special Cost Centers	630,320	35
36	Provider Participation Fee	135,780	36
	D. Other Expenses (specify):		
37	will not tie due to related party info on pgs 3 & 4		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,433,189	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,360,348)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,360,348)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,844	1,919	$ 67,403	$ 35.12	1
2	Assistant Director of Nursing	1,745	1,800	49,388	27.44	2
3	Registered Nurses	38,807	42,848	955,432	22.30	3
4	Licensed Practical Nurses	14,475	14,829	351,729	23.72	4
5	Nurse Aides & Orderlies	94,391	96,585	1,261,419	13.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	290	308	4,080	13.25	8
9	Activity Director	1,976	2,080	46,825	22.51	9
10	Activity Assistants	5,815	6,505	70,477	10.83	10
11	Social Service Workers	2,016	2,072	32,321	15.60	11
12	Dietician					12
13	Food Service Supervisor	1,320	1,400	29,209	20.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,611	40,141	330,235	8.23	15
16	Dishwashers					16
17	Maintenance Workers	2,190	2,238	28,050	12.53	17
18	Housekeepers	23,665	24,284	191,783	7.90	18
19	Laundry	8,603	8,808	71,022	8.06	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,888	1,968	50,121	25.47	22
23	Office Manager					23
24	Clerical	3,796	4,191	53,260	12.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,558	2,595	67,405	25.97	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Cilnical Support	1,874	1,918	36,290	18.92	32
33	Other(specify) personnel	1,968	2,080	33,120	15.92	33
34	TOTAL (lines 1 - 33)	247,832	258,569	$ 3,729,569 *	$ 14.42	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	45,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	5,856	10-2	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,247	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	24	$ 52,603		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Agpasa(4497)/Dalicandro(4015)	administrator	0	$ 8,512
various executives	management	0	68,943
Dipaolo(8173)/Glantz(1359)	administrator	0	9,532
Kanowitz	administrator	0	49,851
Malenok	administrator	0	34,582
Palazzo(4434)/Weber(3962)	administrator	0	8,396
	administrator	0	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 179,816

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management Services	MNGT. FEES	$ 667,982
Blackman Kallick	ACCT. FEES	13,200
Ken Fisch	Legal Fees	34,864
Barry Greenburg	Legal Fees	16,932
Janet L. Herman	Legal Fees	2,507
Various Misc. Prof. Fees	Prof. Fees	565
Medi Code	Software consultant	306
Martin Rubin	Healthcare consultant	2,209
U.S. Gas	Utility consultant	2,418
Healthcare business credit	Audit Fees	3,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 744,482

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,155
Unemployment Compensation Insurance	10,239
FICA Taxes	311,685
Employee Health Insurance	46,543
Employee Meals	34,720
Illinois Municipal Retirement Fund (IMRF)*	
Dental / Life insurance	1,263
Employee relations / Payroll misc. costs	3,191
Employee vaccinations	912
401 K match	1,654
related party-ams	68,837
TOTAL (agree to Schedule V, line 22, col.8)	$ 539,199

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,071
Advertising: Employee Recruitment	
Health Care Worker Background Check	819
(Indicate # of checks performed 117)	
Illinois healthcare association	9,304
American healthcare	200
Fox Valley inspections	2,100
Various misc. dues/subscriptions	595
related party-ams	322
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,411

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,485
Seminar Expense	
related party-ams	13,273
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,758

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Long Grove Rehab & HC Ct # 0040683 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PLUMBING	9/95	$ 2,766	3	$ 615	$ 0	$	$	$	$	$	$	$
2	PAINTING,SMOKE DET	12/95	3,737	3-10	876	128	128	128	128	128	128	128	128
3	PAINTING	1/96	2,369	3	789	0							
4	PAINTING	2/96	1,798	3	599	97	0						
5	PAINTING	3/96	1,844	3	615	102	0						
6	PAINTING	5/96	2,336	3	779	259	0		see page 22A for grand totals….				
7	PAINTING	4/96	12,094	3	4,031	1,008	0						
8	BOILER REPAIRS	5/96	2,100	3	700	233	0						
9	PAINTING	7/96	4,364	3	1,455	727	0						
10	PAINTING	6/96	2,141	3	714	297	0						
11	PAINTING	8/96	4,395	3	1,465	855	0						
12	PAINTING	9/96	1,606	3	535	358	0						
13	CHEMICAL FILTER	11/96	2,229	15	149	149	149	149	149	149	149	149	149
14	PAINTING	12/96	2,331	3	777	712	0						
15	Install compressor(hvac)	6/97	4,125	3	1,375	1,375	573	0					
16	painting	6/97	35,000	3	11,667	11,667	4,861	0					
17	hvac/hot water sensor	6/97	2,322	3	774	774	323	0					
18	water chiller/hvac	7/97	1,800	3	600	600	300	0					
19	boiler controller/hvac	11/97	3,125	3	1,042	1,042	868	0					
20	TOTALS		$ 92,482		$ 29,556	$ 20,382	$ 7,202	$ 277	$ 277	$ 277	$ 277	$ 277	$ 277

Facility Name & ID Number Alden Long Grove Rehab & HC Ct **#** 0040683 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Il Health Care Ass. $9304**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **59,920** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **135,780**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **34,720** Has any meal income been offset against related costs? **yes,ln 2,col 2** Indicate the amount. $ **861**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NO**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BDO Seidman, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number Alden Nursing Center - Long Grove STATE OF ILLINOIS 0040683 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2		3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	**Month & Year Improvement Was Made**		**Total Cost**	Useful Life	Amount of Expense Amortized Per Year								
						FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Climate Srv-repair pump	12/97		1,859	3	620	620	568	0					
2	Custom Appl-a/c's	1/98		2,940	3	980	980	980	0					
3	painting 1998	3/98		4,139	3	1,150	1,380	1,380	230	0				
4	painting 1998	6/98		5,582	3	1,085	1,861	1,861	776	0				
5	painting 1998	9/98		4,240	3	471	1,413	1,413	942	0				
6	painting 1998	12/98		3,014	3	84	1,005	1,005	921	0				
7	H.Scales-abt appliance	8/99		3,034	3		421	1,011	1,011	590				
8	CSI-flow switch/hvac	10/99		3,828	3		319	1,276	1,276	957	0			
9	Capps-sewer rodding	9/99		1,680	3		187	560	560	373	0			
10	CSI- hvac	12/99		2,482	3		69	827	827	758	0			
11	Painting>$1,500 ytd 1999	7/99		13,288	3		2,215	4,429	4,429	2,215	0			
12	CAPPS PLUMBING (SEWAGE CLE	5/00		5,430	3			1,207	1,810	1,810	603	0		
13	VENDOR REC REVERSING			(2,482)	3									
14	GT MECHANICAL (chiller circulatin	8/00		1,523	3			212	508	508	295	0		
15	WRITE OFF CUST MAPP ?			(2,940)	3									
16	Alde Bennett Construction (time & m	12/00		21,314	3			592	7,105	7,105	6,512	0		
17	Painting>$1,500 ytd 2000	7/00		8,699	3			1,450	2,900	2,900	1,450	0		
18	GT Mechan. (hvac repair)	2001		1,507	3				0	502	502	503	0	
	Painting>$1,500 for 2001	2001		2,048	3				341	683	683	341	0	
19	Totals from Page 22 . . .			92,482		29,556	20,382	7,202	277	277	277	277	277	277
20	TOTALS		$	173,666		33,946	30,852	25,972	23,913	18,677	10,322	1,121	277	277